

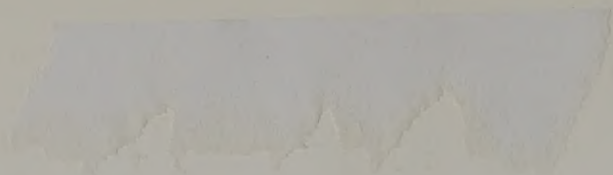


House of Commons
Health Committee

The Use of New Medical Technologies within the NHS

Fifth Report of Session 2004–05

Volume I



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House of Commons
Health Committee

**The Use of New
Medical Technologies
within the NHS**

Fifth Report of Session 2004–05

Volume I

Report, together with formal minutes

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. Written evidence is cited by reference to Volume II of this Report, in the form 'Ev' followed by the page or Appendix number.

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Summary

New medical technologies can bring many benefits to patients, carers and clinicians. They can improve the quality of life of patients through more efficient and effective treatments; enable patients to remain in their homes rather than being admitted to hospitals or care homes; make remote diagnosis and treatment possible; reduce treatment times; and enable clinicians to treat more patients more effectively.

There are limitations to the use of new technologies. They can be expensive, especially if not implemented correctly. Installing new technologies outside the clinical environment, for example in patients' homes, can create problems: patients can find it difficult to use the technology and the reduced human contact with practitioners might also be reflected in reduced contact with carers and kin; alternatively, it might increase the burden of responsibility on carers. However, handled properly these limitations should not be a bar to the wider use of the technologies.

The Department of Health has recognised that the potential benefits of new medical technologies are currently not being realised and that improvements are required. There are several reasons for the slow rate of progress. The NHS comprises a federation of 700 Trusts; inconsistent policies and practices in relation to the development of new technology, its application and purchasing policies create difficulties for suppliers and result in variations in the availability of technologies to patients. The use of different and incompatible makes of equipment leads to many problems, including the need for training in the use of each piece of equipment. The result is a drain on resources and the potential for mistakes. The inability to move money between Trusts' budgets can also result in a lack of integration.

To remedy the current situation the Department established the Healthcare Industries Task Force to improve co-operation between the Government and the healthcare industry. Its report produced a number of recommendations aiming to bring benefits for patients, service users, health and social care services and industry. The Government agreed to implement these recommendations.

Our concern is that they should be implemented fully and effectively. We have made a number of recommendations to build on those of the Task Force:

- an assessment should be undertaken when telecare systems are installed in the domiciliary environment to ensure that equipment is suitable to each individual's needs, with patients, health and social care workers, formal and informal carers, clinicians and technicians being involved in the assessment;
- there should be improved techniques for determining the cost-effectiveness of new technologies;
- nationally approved standards for the commissioning of new technologies should be developed to ensure inter-operability;
- greater effort should be made to strengthen the links between health and social services to ensure the roll out of these technologies in domestic and

community settings is undertaken more effectively than at present;

- there should be a greater engagement of clinical champions for new technologies;
- the Government should address the problems for procurement caused by the inability to move money between budgets; and
- the Government should address the NHS preference for short-term savings as apposed to long-term advantages for patients.

1 Introduction

1. New medical technologies have the potential to transform the way in which health and social care services are provided.¹ According to the NHS Improvement Plan: “evidence indicates that telecare² can bring substantial benefits in providing people with greater choice over their care, assisting people to remain in their homes, reducing inappropriate admissions, facilitating discharge from hospital, and providing advance warning of deterioration in a patient’s condition.”³

2. The UK is a world-leader and centre of excellence for the development of new medical technologies, but it lags behind many countries in the implementation of these innovative products. Sir Derek Wanless⁴ observed the UK has “been slow to adopt and diffuse new technologies”⁵ resulting in it “lagging behind many other countries.”⁶

3. We announced our intention to hold this inquiry in December 2004 with the following terms of reference:

The Committee will undertake a short inquiry into the use of new medical technologies within the NHS. In particular, this will include consideration of:

- *The utilisation of telemedicine (including telecare) and its future potential for improving services*
- *The recommendations of the Healthcare Industries Task Force (HITF) Report, published 17 November 2004*
- *The speed of, and barriers to, the introduction of new technologies*
- *The effectiveness and cost benefit of new technologies.*

We decided to exclude from the scope of the inquiry the National Programme for Information Technology (NPfIT) and pharmacological technologies owing to the shortness of the inquiry. Moreover, the Committee had examined these areas recently.

4. People are living longer and surviving previously life-threatening illnesses, due in part to advances in medical science. The population is an ageing one, which requires a different range of services to help manage long-term conditions and to support independent living. New medical technologies can assist elderly people and those with disabilities to be cared

¹ Ev 30

² Telecare – includes systems that incorporate electronic devices that can alert the occupant of a house or a care response system on the occurrence or non-occurrence of predetermined events. Ev 38

³ Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, Cm 6268, June 2004, p 67

⁴ Sir Derek Wanless, carried out the Health Trends Review at the request of the Chancellor of the Exchequer. In April 2002, he produced the report *Securing our Future Health: Taking a Long-Term View*. He continued his advisory work for Government in October 2002 when he agreed to advise the Welsh Assembly Government in its review of health and social care. He undertook further work for the UK Government and in February 2004 published *Securing Good Health for the Whole Population*.

⁵ Derek Wanless, “*Securing Our Future Health: Taking a Long-Term View*”, HM Treasury, April 2002, p 157

⁶ Derek Wanless, “*Securing Our Future Health: Taking a Long-Term View*”, HM Treasury, April 2002, p 156

for in their homes, as well as in hospital, residential and care settings. Accordingly, we were particularly interested in the care of the elderly and how new medical technologies could assist in the integration of health and social care.

5. On 3 March 2005 we took oral evidence from Professor Carl May, Centre for Health Services, University of Newcastle upon Tyne; Mr Baljit Dheansa, Queen Victoria Hospital NHS Foundation Trust (QVH); Mr John Wilkinson, Association of British Healthcare Industries (ABHI); Professor Sir James Underwood, President, Royal College of Pathologists; Mr Tony Rice, Tunstall Group Ltd; Dr Felicity Harvey, Professor Tom Walley and Professor Ian Philp, Department of Health (hereafter 'the Department'); and Sir Christopher O'Donnell, Co-Chairman of the Healthcare Industries Task Force.

6. In addition we received written memoranda from a variety of professional bodies, companies, academics, independent consultants, charities and clinicians. We are most grateful to all who provided written or oral evidence.

7. Our specialist advisers in this inquiry were Professor Andrew Webster, Professor in the Sociology of Science and Technology at the University of York and Melanie Henwood, an independent health and social care analyst. We wish to express our gratitude to Professor Webster and Melanie Henwood for their help on technical matters, for giving us the benefit of their knowledge and for the enthusiasm and expertise with which they assisted us at the evidence session.

2 Structure of the healthcare industry

8. The medical technology industry in the UK is extensive, diverse and innovative. It covers a wide range of medical consumables, hospital supplies and equipment, devices used in the community and services. It is a significant component of the UK economy and has potential for considerable growth. The industry in the UK consists of approximately 4,800 companies, with 85% having a turnover of less than £5 million per year.⁷ It employs in excess of 55,000 people, has combined annual sales of £6 billion⁸ and accounts for £3 billion of export earnings.⁹

9. The NHS is the main purchaser of medical devices and is an important market for Information Technology equipment and services. In an effort to bring closer co-operation between the Government, the NHS and healthcare companies the Healthcare Industries Task Force was announced in October 2003. The aim of the HITF is to bring benefits for:

- patients and service users;
- the NHS;
- social care;

⁷ *Better health through partnership: a programme for action*, Healthcare Industries Task Force, November 2004, p 16

⁸ Ev 6

⁹ "UK's medical technology industry has hit £3bn exports", ABHI press release, 10 February 2005

- and to help improve the healthcare industry's performance.¹⁰

10. Research is key to this industry. The industry spends approximately £380 million per annum on research and development. The Government provides a large amount of funding. The Department of Health's budget for NHS research and development is over £600 million in 2004-05, of which £480 million is allocated to NHS providers¹¹. 75% of the money from these allocations meets the service costs to the NHS of research funded by research councils and charities.¹²

11. A number of organisations exist to bring together healthcare companies, patient groups and clinicians to improve co-operation and communication in the development and implementation of medical technologies. The Association of British Healthcare Industries is the leading trade association for the medical systems industry. Its aims are to advance and promote medical systems (devices, equipment, technologies and services) within the UK and globally, and to provide a forum for policy discussion with the industry's customers, legislators, public bodies and interested groups.¹³ The Medical Technology Group (MTG) is a coalition of patients, patient groups, medical professionals and the industry keen to widen the availability of medical technologies in the UK.¹⁴

3 Potential benefits and limitations of new medical technologies

Benefits of new medical technologies

12. The Department has identified a number of benefits that can be provided by new medical technologies. Both the NHS Plan¹⁵ and the NHS Improvement Plan¹⁶ advocate the use of telemedicine to support and transform the delivery of healthcare. Telecare and telemedicine enable patients to be treated outside hospital settings and by assisting the work of GPs and Primary Care teams enabling more elderly people and those with chronic illnesses or disabilities to live independently.¹⁷

13. In addition to improvements in the quality of life of patients, efficiency gains to the health and social care systems are possible because 'just-in-case' admissions of older people to hospital and residential care are still common. The Department stated that telecare and related technologies can allow:

- avoidance of unnecessary hospital admission and timely discharge;

¹⁰ *Better health through partnership: a programme for action*, Healthcare Industries Task Force, November 2004, p 5

¹¹ NHS providers – companies and academia external to the NHS

¹² Ev 31

¹³ *About ABHI – Overview*, <http://www.abhi.org.uk>

¹⁴ *Making the Economic Case for Medical Technology*, The Medical Technology Group, November 2003

¹⁵ Department of Health, *The NHS Plan: a plan for investment, a plan for reform*, Cm 4818, July 2000

¹⁶ Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, Cm 6268, June 2004

¹⁷ Ev 39

- falls prevention strategies;
- saving lives through more reliable fire/smoke detection for older people;
- timely information to inform people's care package reviews;
- improving quality of life and reducing care costs for people with long term conditions and with strokes;
- and better monitoring of people with chronic obstructive pulmonary disease and diabetes which can alert to changes in condition and significantly reduce out-patient attendances.¹⁸

The Department also identified significant opportunities for the use of Information and Communications Technology (ICT) to improve the quality of care and to meet patient expectations. These include:

- improving efficiency and streamlining the work of professionals;
- monitoring, performance management (clinical & non clinical) and clinical governance, dissemination of evidence based best-practice;
- convenience;
- joined-up working throughout the NHS and social care;
- and reduction in human errors (e.g. computerised checking of dispensed medicines)

14. In his oral evidence Mr John Wilkinson, Director General of the Association of British Healthcare Industries, provided two examples of how new technologies can improve the quality of life of users, and their families. The first related to the implantation of a device to monitor the heartbeat of children who suffer from potentially fatal cardiac arrhythmias.¹⁹ Mr Wilkinson told us that the stress for the child and family of living with the condition "does not bear thinking about." He continued:

The technology is available to implant a device which monitors the heartbeat and when it starts behaving badly it effectively gives it a jolt and gets the thing going, so that the fear of going to bed one night and kissing your child goodnight and waking up the next morning and finding him a lifeless corpse is eliminated; it is very profound.²⁰

He then provided a second example:

I met a patient who had severe Parkinson's Disease, shuddering severe Parkinson's Disease, of the sort in which the physical manifestations are profound but the psychological effect is even more profound and you become a social leper effectively and really do not want to present yourself to the world. One of our member

¹⁸ Ev 39

¹⁹ Cardiac arrhythmia is a term that denotes a disturbance of the heart rhythm.

²⁰ Q 48

companies has a technology which allows you to implant electrodes in the brain and provide minute electrical stimuli, and you can walk up to this chap who is standing at a bar with a pint in his hand, rock solid, shake his hand and have a conversation and you would not be able to distinguish him from any of us sitting in this room. It has profound impact on that person's life; he has a productive job, he is engaged in normal life.²¹

15. Over recent years the Queen Victoria Hospital NHS Foundation Trust, East Grinstead, has developed a telemedicine system that enables referring hospitals to electronically transmit images and clinical information in a secure manner. The QVH telemedicine project was established in 1999, involving three local A&E departments that regularly referred patients to the QVH Trust. Images from a digital camera installed at each referring A&E department were transmitted via email to QVH. Following the initial success of the pilot additional sites were included and the system has been further developed. Mr Baljit Dheansa, Consultant Burns and Plastic Surgeon, QVH, told us that he was able to view transmitted images of potential referrals while he was in the operating theatre treating another patient; as a result the patient did not have to be transferred to QVH for an initial opinion and the surgeon did not need to leave theatre to provide it.²² Mr Dheansa emphasised that having clinical champions to sponsor the implementation of new technology was key to success: "Providing that support enabled doctors in those units to see the benefits of those cases where telemedicine was useful..."²³

16. QVH have, therefore, succeeded in taking a pilot study to full operation by implementing a simple, practical system while keeping clinicians and IT support staff engaged and allowing users to drive and support the system. The system developed by QVH and the process of implementation is an example of how a telemedicine model should be developed and introduced. Telemedicine is seen by QVH as playing an integral part in future service development of the Trust.²⁴

17. We recommend that Trusts be encouraged to identify 'clinical champions' to promote the benefits of telemedicine within the Trust and to ensure that the organisational and staff development requirements to make the system workable are in place. It is crucial to establish policies that enable the lessons of pilot programmes to be used in clinical delivery: at present it is often the case that the organisational requirements of integrating telehealthcare systems into hospital and primary care settings are rarely considered in R&D pilots.

Limitations of new medical technologies

18. While many benefits may accrue from the use of new technologies we were informed that 'formal studies' have indicated that they are "by no means a panacea."²⁵ In some circumstances telemedicine can be more expensive than conventional alternatives.

²¹ Q 48

²² Q 26

²³ Q 25

²⁴ Ev 4

²⁵ Ev 40

Moreover the Department pointed out that if telemedicine is to succeed a number of important 'process issues' have to be addressed.²⁶ Studies have indicated that unless telemedicine is quick, easy to use, efficient and reliable, and crucially does not increase GPs' workloads, it would be unlikely to find widespread acceptance.²⁷

19. Mr Wilkinson, of ABHI, informed us that problems with new technologies can occur when they are installed outside of a clinical setting, for example, in people's homes. He said: "If you transfer the focus of care from a highly controlled environment into a less controlled environment...then you need to build quality systems to manage that, particularly if patients are involved..." He added that in this situation patients "need to be full stakeholders."²⁸ Mr Wilkinson recommended that engaging with patients and patient groups was crucial to the success of effective use of new technologies. When questioned further on this subject he said: "I think often technologies are looked at as very technical solutions by technical people to specific problems and I think further engagement with patients and understanding the real impacts of these technologies on their lives can only be good."²⁹

20. We are concerned that the installation of telecare monitoring systems in people's homes could deny patients vital human and social contact. Professor Ian Philp, National Director for Older People's Services, Department of Health, when we questioned him about the possible decrease in human contact, replied: "From an older person's point of view, the human factor is the most important." He continued: "We can use telecare at a low level or a very high level but it does depend on the level of dependency and the need of the individual, and not to intrude beyond what would be acceptable for them enjoying an independent quality of life and a degree of autonomy."³⁰

21. We recommend that when telecare systems are installed in the domiciliary environment, clinicians, technicians, health and social care workers, formal and informal carers and, most importantly, the patient are involved in determining the level of telecare that is suitable and acceptable to each individual recipient. It is essential that a balance between the use of technology and the continuation of human contact is an important element in any such judgement.

22. Furthermore, evaluation needs to take account of the qualitative benefits for users and carers over time. There is a need to develop new ways of evaluating the qualitative benefits of new medical technologies in the long-term budgetary cycles. Methodologies are needed that can determine the social and economic benefits of new medical devices that fall outside the direct costs to the NHS.

23. We recommend that the Department should seek to introduce a national system for reviewing and tracking the implementation of new devices over a number of years to ensure patient safety and efficacy issues are closely monitored. Currently there is no clear system for determining safety and efficacy beyond the clinical trials and evidence-

²⁶ Ev 40

²⁷ Ev 40

²⁸ Q 47

²⁹ Q 49

³⁰ Q 93

based model of the Health Technology Assessment (HTA) programme while, there is also a need for developing more sophisticated measures of the utility of systems for patients that reflect more relevant criteria. Much greater patient participation in assessing the utility of telehealthcare is required.

24. A balance also has to be established between national standardisation, that could possibly remove competition between innovators, and a situation where different and incompatible types of the same equipment are installed in individual hospitals, or even wards, due to non-standardisation. Professor Sir Christopher O'Donnell, Co-Chairman of the Healthcare Industries Task Force, told us that they were “looking for a clear case for the benefits [of standardisation] and obviously the costs of any particular device, but ... it is best practice to have one or at most two [types] per facility – hospital or whatever – and then make decisions after whatever time to replace the whole lot...[otherwise] you end up with a creeping mix of equipment.”³¹

25. The Department should ensure that Primary Care Trusts (PCT) and hospital trusts (and if possible SHAs) should commission new technologies according to nationally approved standards (determined by the new Device Evaluation Service [DES] in conjunction with HTA/National Institute of Clinical Excellence [NICE]). Such standards should provide the basis for the selection of base-line devices and technologies. It is important that the tendency towards technology ‘creep’ and uneven mix of systems that lack interoperability or require different competences to be used should be avoided. Standardisation on clinical based systems should be undertaken in light of discussion with Social Services, who have a greater responsibility for telecare.

26. While the application of telecare and ICT can have many advantages for patients and carers, the privacy of the individual must also be considered. The Department highlighted the fact that confidentiality and privacy are recurrent issues in the introduction of new technology. In its submission the Department noted that technology can facilitate home telecare and home telemonitoring and alert care teams to a health problem, but this has to be balanced against patients’ rights to privacy.³² We were impressed by the approach at QVH which has implemented a successful protocol to ensure privacy and confidentiality in relation to the photographing and video recording of patients.

27. We recommend that, when new medical technologies are introduced, protection of confidentiality and the privacy of the individual are key factors in the decision-making process. Privacy and confidentiality policies and protocols should be developed, implemented and audited when new technologies are introduced.

4 Why benefits are not being realised

28. The Department has recognised that it could do more to facilitate the introduction of new medical technologies into the NHS. Dr Felicity Harvey, Head of Medicines, Pharmacy and Industry Group, Department of Health, told us: “the NHS has not been good at getting

³¹ Q 78

³² Ev 40

new technology in.”³³ In its memorandum the Department pointed out that NICE has made a contribution to improving the NHS’s understanding of the clinical efficacy and cost-effectiveness of new medical technologies, but recognised that “more needs to be done to improve implementation of NICE guidance”³⁴ — a point that we have identified, and made recommendations about, in several of our previous inquiries.³⁵

29. Witnesses highlighted evidence from other countries that have higher rates of take-up of new technologies. Mr Wilkinson told us, for example, that in Germany over 40,000 diabetes patients use insulin pumps, while in the UK the figure was less than 2,000. He believed this reflected problems of silo budgeting³⁶ in the UK and lack of “involvement of clinicians in the procurement process and particularly the evaluation of technologies and translation of those through everyday use.”³⁷

30. There are specific reasons for other countries having a superior record to the UK of implementing new technologies. Professor Sir James Underwood, President of the Royal College of Pathologists, commented that there were often fewer specialists in some countries such that there was much greater incentive and economic rationale for adopting telemedicine.³⁸ In Scandinavia the population is sparsely distributed and many hospitals do not have on-site services. These services, can now, be delivered and supported by telemedicine. However, some countries, with better records of implementing new medical technologies, are simply better at realising the benefits than the UK.

31. Written evidence, notably that from the Medical Technology Group, provided further information about other countries (see figure 1). Such figures need to be treated carefully, for level of expenditure in itself cannot be regarded as a measure of efficacy or effectiveness in the acquisition and use of new systems or devices. Nevertheless, the figures illustrate that the overall level of spend on medical technologies within the UK as a percentage of Gross Domestic Product is considerably lower than the European average and that of the US.

³³ Q 57

³⁴ Ev 32

³⁵ Health Committee, Second Report of Session 2001-02, *National Institute of Clinical Excellence*, HC515, paras 76, 80 and 81 and Health Committee, Second Report of Session 2004-05, *The Prevention of Venous Thromboembolism in Hospitalised Patients*, HC99, para 58

³⁶ Silo budgeting - the inability or unwillingness to move money between health and social care budgets at government and regional level, and in hospitals with budgetary allocation systems discouraging the movement of funds from long stay wards to day surgery care or even simply between two in-house departments.

³⁷ Q 3

³⁸ Q 10

Figure 1 : Expenditure on medical technologies by selected countries, as a proportion of total healthcare expenditure and Gross Domestic Product.

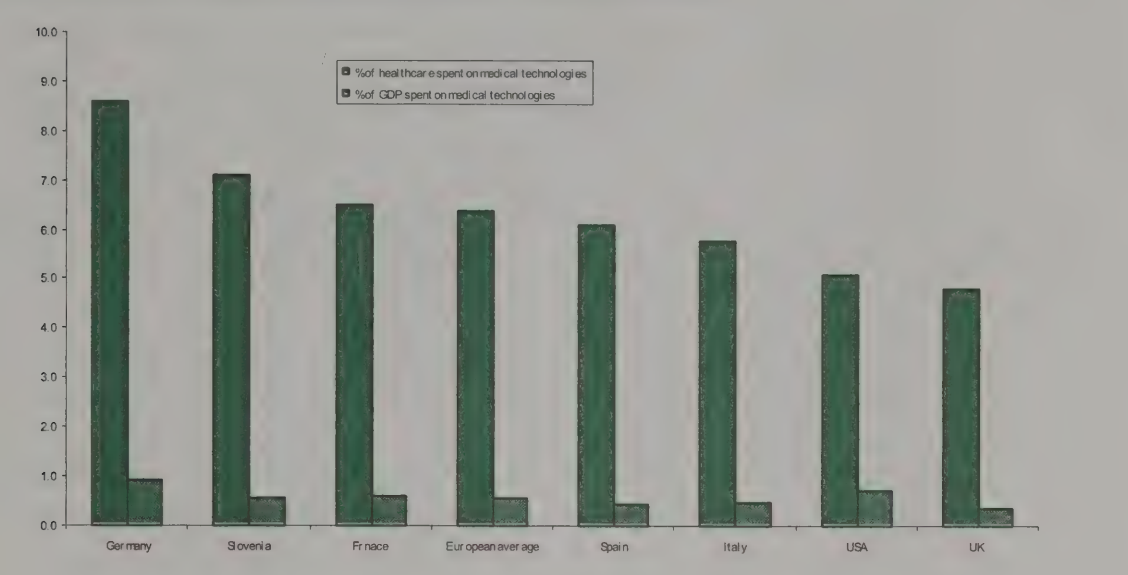


Table 1: Expenditure on medical technologies by selected countries, as a proportion of total healthcare expenditure and Gross Domestic Product.

Country	% of healthcare spent on medical technologies	% of GDP spent on medical technologies
Germany	8.6	0.92
Slovenia	7.1	0.57
France	6.5	0.62
European average	6.4	0.55
Spain	6.1	0.46
Italy	5.8	0.50
USA	5.1	0.71
UK	4.8	0.36

Data source: The Medical Technology Group, Ev 65

32. It was pointed out to us that while the NHS is seen by many as being a single organisation it is in fact a federation of more than 700 Trusts, with different and inconsistent policies and practices on new technology development, application and purchase.³⁹ Professor Carl May and colleagues in their submission stated: “The absence of a central policy sponsor and central funding stream for R&D, procurement, and service development is the key barrier to these new developments. It is worth contrasting this with the rapid development and delivery of mechanisms for telephone triage, advice and service delivery (NHS Direct, NHS 24).”⁴⁰ This has led to what some written and oral evidence described as a ‘postcode lottery’ in regard to the geographical availability of new

³⁹ Ev 3

⁴⁰ Ev 3

technologies funded by PCTs: best practice is not available across the country and NICE recommendations are adopted very unevenly.⁴¹ The diversity across NHS Trusts has resulted in incompatible and inconsistent procurement policies. It can, as Professor May, of the Centre for Health Services Research, University of Newcastle upon Tyne, argued, place “a huge obstacle to industry in negotiating its way through the procurement pathway”.⁴² A number of witnesses suggested it can lead to the procurement across Trusts of a wide range of devices and therapies that reflect, as Sir Christopher O'Donnell argued, ‘a creeping mix’ of equipment, rather than necessarily more clinically efficacious and cost-effective systems.⁴³ While NHS Trusts are clearly not averse to adopting technologies, they are not doing so in an integrated, rational or strategic way.

33. Even where a technology has been recommended by NICE, the large number of ‘entry points’ into the NHS through Trusts results in technology being evaluated locally and, thereby, subject to considerable delay and unevenness in its implementation. This can cause considerable difficulties for smaller companies. As Sir Christopher O'Donnell noted: “if every one of the Trusts who are thinking about using something decides it wants to do an evaluation, it (a) slows things down and (b) is a diabolical use of overall resources.”⁴⁴

34. This organisational and technical complexity in evaluation and procurement means that a key barrier to more effective use of medical technologies is the acquisition of discrete and often incompatible systems and devices, or ones that require quite different training and competences to use, even within the same hospital or other clinical setting. As Mr Tony Rice, Chief Executive, Tunstall Group Ltd., observed: “it is very easy to go for a number of high technology solutions that are incompatible”⁴⁵

35. This question of incompatibility arises elsewhere too. Concern was expressed that existing digital based systems and diagnostic tools, especially used in radiology or pathology, may not be fully compatible with the NPfIT. As Professor Sir James Underwood argued:

Our concern is the interface between our laboratory information systems and NPfIT. We do have concerns about the lack of seamlessness at the interface between our laboratory systems and the National Programme.⁴⁶

While the NPfIT may provide for the first time, as Dr Felicity Harvey noted, “a national capability” that will enable more effective use of telemedicine and telecare, its role in the wider ecology of diagnostic lab-based techniques is still to be defined.⁴⁷

36. This lack of integration is exacerbated by the existence of silo budgeting within Trusts, and until recently relatively short-term, annualised budgets within which the

⁴¹ Q 46

⁴² Q 9

⁴³ Q 78

⁴⁴ Q 64

⁴⁵ Q 41

⁴⁶ Q 11

⁴⁷ Q 59

commissioning process has had to operate. Recent changes towards a three-year budgetary cycle for PCTs should help to overcome this problem.

37. However, annualised budgets have left a legacy inasmuch as it has been difficult to demonstrate utility of new technologies across discrete budgetary silos. Whether extending the budgetary cycle will break this down is open to question.

38. There is often little incentive for organisations to invest in new technologies, when these may benefit others or when the investing organisations will not be reimbursed for developing new systems. Mr Dheansa, of Queen Victoria Hospital, explained that his hospital was placed at a “financial disadvantage” when it implemented its system. He informed us that QVH had spent £85,000 developing a system, but had not been reimbursed for that cost although the Trust gained “in terms of efficiency and appropriate theatre and bed utilisation”.⁴⁸ Moreover, the very characteristic of some technologies, such as telecare or telemedicine, means that the trust which pays for the new technology is not necessarily the Trust which benefits from it.

39. This links to the general question of how technologies are evaluated and whether this is, unintentionally, an additional barrier to implementation. Clearly, no technology should be adopted without thorough evaluation, but how and what this means is not a simple matter. Short- and long-term benefits have to be considered. While cost-efficiency is seen as an advantage of new medical technologies, doubts have been raised about the evaluations of the true cost-effectiveness. Professor Carl May told us that cost-effectiveness is

sometimes in doubt ... largely because of the poor quality of most of the economic evaluations that have been done. The truth is that we do not know whether these systems are cost effective – not that we say that they are not cost effective – and that is because the economics of the National Health Service are really some of the most extraordinarily Byzantine things in the history of humanity.⁴⁹

He continued by saying: “the published evidence about cost-effectiveness is often of methodologically very poor quality.”⁵⁰ Attempting to place a price value on improvements in a patient’s quality of life provided by the use of new medical technologies further complicates any attempt to accurately evaluate cost-effectiveness. It is also difficult to accurately calculate cost-efficiencies obtained through the increase in the number of patients that can be treated in primary and secondary care through new medical technologies and the subsequent reduction in delayed discharges, reduced waiting times and reduced surgery times.⁵¹

40. Several witnesses suggested that there is a need for the development of methodologies that can provide for much longer-term review of the net benefits of new systems or devices. Much of the evaluation depends on clinical trials to provide evidence upon which to make a cost-benefit analysis. These can take considerable time, quite legitimately so, to determine this. Firms complain about the delays this can cause in relation to the introduction of their

⁴⁸ Q 38

⁴⁹ Q 42

⁵⁰ Q 43

⁵¹ Ev 73

products, a point also made by some patient advocacy groups. Getting the balance right between thorough evaluation and the speedy introduction of new medical technologies can be difficult, and is reflected in the tension between Government policies, as Professor May noted between:

the modernisation stream which seeks to use technological innovations to move services forward very rapidly and to develop their patient centred services, services which have a degree of local participation and which cross organisational boundaries, and the policy stream that demands evidence-based practice because the production of evidence always takes a very long time if it is going to be formed in a way that will satisfy the demands of clinicians and budget holders.⁵²

41. Clearly there are good professional reasons why new technologies should be adopted with caution, recognising that usefulness of new technologies depends on the circumstances. In some circumstances, rather than introducing whole new systems — such as telepathology to replace microscopy in histopathology labs — the conventional systems, here microscopes, are themselves being improved through digitisation. Whatever the specific technical features of a system, witnesses pointed out that any technology is likely to involve considerable ‘behind the scenes’ work to make it feasible: one has to “re-engineer the whole way you manage patients.”⁵³ Clearly, this can act as a disincentive to the introduction of new technologies and thereby the benefits they may bring. The success of telemedicine reported in the QVH example described above (paragraph 15) depended on that Trust identifying a ‘clinical champion’ whose role was to help change practice and procedure in order to demonstrate benefit and enrol other members of the health team.

42. It was also pointed out to us that ‘benefit’ has to be related to quality assurance provisions in regard to the deployment of new technologies, especially the growing number of near-to-patient devices appearing today. Standards requirements need to reflect the risk to patients that inadequate or limited testing might create. Moreover, benefit needs to take account of the impact of new systems on carers who may be reluctant or unable to take on new and additional responsibilities.

43. The final, perhaps most important barrier that many drew attention to through both written and oral evidence was the gap between health and social care services. The Government now claims to be addressing this through pooled budgets and use of other flexibilities, but there is clearly much more to be done. In part this relates to a wider sense of the notion of budgetary ‘silos’ this time between Trusts and Councils and a situation where the risks and benefits are not equally shared. As Professor May told us: “The failure of the NHS to engage with telecare systems comes back to the problem where the benefit lies. The benefit for telecare lies largely “in the field of social services because it manages often elderly, often disadvantaged, often very vulnerable people remotely.”⁵⁴ Mr Rice told us:

Telecare of course is preventative and it is funded by social services and acute care is funded by the Department of Health and therefore the removal of people from the

⁵² Q 9

⁵³ Q 44

⁵⁴ Q 42

acute sector, which saves the Department of Health money, imposes an additional cost burden on social services, and until we find a way to pool those budgets ... then I think the budgets and responsibilities being divided will continue to mean that we are sub-optimal in our utilisation of new technologies.⁵⁵

5 What the Government proposes to do

44. The Department has recognised that improvements are required in the development and introduction of new medical technologies. It has already started to address the current situation through a number of initiatives, such as the Healthcare Industries Task Force. Dr Harvey told us that the Department would generate an impetus “to catch up with those other countries, whose innovation and entrepreneurial culture is possibly indicated more in terms of how they deliver services now.”⁵⁶

45. The Healthcare Industries Task Force was established to explore issues of common interest and identify opportunities for co-operation between the Government and the healthcare industry that would bring benefits for patients and service users, health and social care services and industry.⁵⁷ It was a year-long initiative, launched in October 2003. With a wide-ranging and complex agenda the key issue was how to improve patient access to healthcare products, particularly beneficial new technologies. It also examined the development of practical measures to stimulate more innovation in the industry and the NHS, and the modernisation of NHS procurement.⁵⁸ The Task Force published its report, *Better health through partnership: A programme for action*⁵⁹, in November 2004.

46. The report outlined an ambitious work programme that included:

- a modernised Device Evaluation Service which will be managed by the NHS Procurement and Supply Agency (PASA) – target date 1 April 2005
- development of an Innovation Centre to stimulate and promote innovation in the NHS as part of an appropriate organisation
- piloted Healthcare Technology Co-operatives as academic centres of excellence - pioneering specialist treatments and techniques
- building R&D capacity for medical devices through UK Clinical Research Collaboration Research
- improved training and education of NHS staff on the use of medical devices
- maximising the UK’s influence in regulatory matters in the EU and worldwide
- a focused export strategy for the UK healthcare sector

⁵⁵ Q 8

⁵⁶ Q 57

⁵⁷ *Better health through partnership: a programme for action*, Healthcare Industries Task Force, November 2004, p iii

⁵⁸ Ev 35

⁵⁹ *Better health through partnership: a programme for action*, Healthcare Industries Task Force, November 2004

- more informed, efficient procurement
- better communication with patients and the public on the valuable role played by healthcare products in our daily lives
- a new data collection system to gain a clearer picture of the industry and its performance.

47. The Device Evaluation Service, currently part of the Medicines and Healthcare products Regulatory Agency (MHRA), evaluates medical devices and equipment used for pathology, diagnostic imaging, life support and assistive technology⁶⁰. The aim is to provide independent and impartial advice to inform purchasing decisions and encourage the safe use of medical devices based on technical assessment and user comments. The DES “is of particular interest to anyone involved in the purchase, management or use of medical devices.” It enables users to select the most suitable devices for their needs, provides information to purchasers of supplies and encourages the safe use of equipment. The Service also contributes to the improved equipment design and performance of medical devices.⁶¹

48. The HITF report recommended that the DES should move from the MHRA to the NHS Purchasing and Supply Agency with effect from 1 April 2005. Sir Christopher O'Donnell told us that the DES was being moved to PASA “to make it an integral part of that service, so that it gives the service the ability actually not just to make unit-cost based decisions but to look at how value and innovation can be brought to bear.”⁶² The role of the DES would then be to inform procurement decisions, and encourage and support the uptake of useful, safe, innovative products and procedures used in health and social care. It would:

- develop a new device evaluation service to integrate and strengthen horizon scanning, and the assessment of value and effective performance of new and enhanced healthcare technologies, devices and related procedures;
- develop nationally accepted methodologies and toolkits for device evaluation that can be used locally to ensure consistency of approach whilst facilitating decision-making at the appropriate level;
- and consider how best to ensure speed of evaluation, a ‘once only’ approach and prompt sharing of outputs with stakeholders throughout the health and social care system and industry.⁶³

49. The Department informed us that the new DES would be at the hub of a wide-ranging network, joining industry with NHS clinicians and purchasers, with access to expertise in the field.⁶⁴ Sir Christopher O'Donnell said: “a company brings something that is a product

⁶⁰ Assistive technology - Any item, piece of equipment, or system, whether acquired commercially, modified, or customized, that is commonly used to increase, maintain, or improve functional capabilities of individuals with disabilities.

⁶¹ Device Evaluation Service Information, <http://www.medical-devices.gov.uk/mda>

⁶² Q 64

⁶³ *Better health through partnership: a programme for action*, Healthcare Industries Task Force, November 2004, p 1

⁶⁴ Ev 35

in production, appropriately signed off in terms of the quality assurance standards related to the EU Directive and so on, that device can then be evaluated – and evaluated once, not evaluated 246 times or whatever the number happens to be at the available centres.”⁶⁵

50. In its memorandum, however the ABHI stated that there were a number of threats to the successful implementation of the HITF report that could prevent fair and appropriate access to treatments and technologies for patients. The two identified threats were:

- Unclear accountability for each output’s implementation;
- and an NHS preference for short-term savings to be made, at the expense of long-term advantages for patients.⁶⁶

51. We welcome the initiatives in regard to a relocated and revised DES. However, Professor Sir James Underwood, of the Royal College of Pathologists, suggested that there should be a single regulatory framework for all diagnostic tests, whether Point-of-Care Testing or laboratory based.⁶⁷ **There is also a need for a system of reporting with regard to the utility and limitations of telehealthcare systems or other devices that are ‘near to patient’.** It is clear that this will not be the responsibility of the reshaped DES, and there is currently no national ‘clearing house, where this information might be lodged. This may well be a function for the Healthcare Commission.

52. The Government’s report on the reconfiguration of Arm’s Length Bodies⁶⁸ announced that the Department was combining the work of the NHS Modernisation Agency, the NHS Leadership Centre and the NHS University into a single NHS Institute for Learning, Skills and Innovation (NILSI). The NILSI will promote excellence and innovation across the health and social care system and enhance service delivery in the NHS. The Department further informed us that the Institute would assume a leadership role in the implementation and delivery of change in the NHS and manage the new Innovation Centre.⁶⁹

53. Dr Felicity Harvey told us that the NILSI would be “a strategic oversight for training and development of staff.”⁷⁰ However, she continued by informing us that the HITF had not had sufficient time to get “to really get to the bottom of” the whole area of training and development. The MHRA are already looking at the development of a medical device driving licence that looks at modules of training that people require for individual devices. This is shortly to be piloted in conjunction with the Royal Colleges. Dr Harvey also informed us that industry provides a “huge amount of training for clinicians around the use of devices”.⁷¹ With the preponderance of different models of devices it is important for patient safety that users of the equipment are trained on all of the devices. She told us that

⁶⁵ Q 64

⁶⁶ Ev 6

⁶⁷ Q 32

⁶⁸ “Reconfiguring the Department of Health’s Arm’s Length Bodies”, Department of Health, July 2004

⁶⁹ Ev 34

⁷⁰ Q 74

⁷¹ Q 74

the Department has recognised that it needs to work with the Royal Colleges, with Skills for Health, and with NILSI to develop a coherent strategic way forward.

54. The Government has proposed some improvements to training, but these will not be sufficient. The Department should ensure that adequate training is in place to enable greater benefits to be derived from new technologies. To encourage greater familiarity with the possibilities and opportunities as well as limitations and risks of telemedicine, training should be modified in those specialist areas that are most likely to be primary users of telehealthcare such as pathology and radiology. Medical schools as well as the professional bodies should develop programmes to ensure effective training is put in place. Training in telecare for health care assistants working for social services and in the community also requires improvement to gain full benefits of new technologies.

55. In its memorandum the ABHI stated: “effective procurement by the NHS is at the heart of successful delivery of medical technology to patients.”⁷² The Department stated:

NHS procurement is being brought into line with Government policy with the aim of ensuring the purchase of high-value products that perform effectively. The sharing of best practice between local purchasers and commissioners is improving the quality of decision-making, and the development of regional procurement hubs is enabling better value-for-money procurement. Centrally-managed procurement of high investment medical equipment continues to ensure that the NHS benefits from such programmes.⁷³

Because of the short-comings in the current arrangements for purchasing within the NHS, the Department is incorporating the recommendations made in the HITF report relating to purchasing into the redesign of PASA. Dr Harvey informed us of three pilot collaborative procurement hubs⁷⁴ which are seen as “being very important in terms of purchasing for the future.”⁷⁵

56. We were told that enormous efforts have been made by the Department to design and implement a system of Payment by Results (PbR) to “create a fair transparent system for paying NHS hospitals and other NHS service providers.”⁷⁶ The Medical Technology Group pointed out in its memorandum that, while PbR promises to bring new efficiency and improved performance, the current transition to Healthcare Resource Groups (HRG) as the central method of achieving payment by results in English hospitals risks the use of tariffs that do not reflect the true costs of patient care for a number of critical technologies.⁷⁷ The ABHI informed us that tariffs for medical technologies are set according to the national reference cost for each HRG. In its memorandum it stated that: “some procedure payments appear to be so inadequate, they would fail to cover the cost of

⁷² Ev 7

⁷³ Ev 34

⁷⁴ Collaborative procurement hub pilots – Greater Manchester SHA, West Midlands South SHA and Shropshire and Staffordshire SHA Q 76

⁷⁵ Q 76

⁷⁶ *Sharing the learning: Payment by results*, Department of Health website, <http://www.dh.gov.uk/PolicyAndGuidance/>

⁷⁷ Ev 66

the technology alone.”⁷⁸ We questioned Mr Wilkinson about this subject. He replied that the members of his organisation had:

some concerns ... in terms of implementation and the capacity of the system at the moment to generate accurate, reliable tariffs. There is also a concern that if this massive process of generating large numbers of tariffs is slow then new technologies will not be reflected in the tariffs, or they will be reflected very late.⁷⁹

57. The Medical Technology Group also voiced concerns. They pointed out that tariffs are calculated on the previous two year data submitted by hospitals. They had concerns about inaccuracies in data being used to determine tariffs and that for newer technologies two years data will not be available to calculate the true cost of the tariff.⁸⁰

58. In July 2004 Dr John Reid MP, Secretary of State for Health, announced a new set of national targets. Included in the new targets was an 18 week maximum wait from start time to treatment by 2008.⁸¹ **The Payment by Results scheme has been said to provide an incentive for new technologies, given its tie-in with the 18 week treatment target for patients (thereby encouraging Trusts to select those technologies and devices that can speed up care to meet the 18 week target). Devices that enable this to happen should be a key priority for the new DES. Given that in some cases the Trust that purchases and invests in new technologies may not necessarily be the beneficiary (or sole beneficiary), we recommend that the Department should build into the PbR tariff an incentive payment to offset these development and on-going costs.**

59. There is a need to differentiate tariffs for specialised devices/technologies and those that relate to basic care provision to ensure that the reimbursement structure properly reflects the level of complexity and pattern of use of new medical technologies.

60. We welcome the initiatives already undertaken by the Department in this area. Now it must ensure that it devotes adequate attention and resources to rectifying the currently unstructured adoption of new medical technologies.

61. We recommend that the Government in addition to its current proposals should address the following issues of concern to the Committee:

- problems relating to the inability to transfer budgets between holders;
- lack of clinical engagement and clinical champions;
- the impact of practice based commissioning on procurement; and
- an NHS preference for short-term savings to be made as opposed to long-term advantages for patients.

⁷⁸ Ev 7

⁷⁹ Q 52

⁸⁰ Ev 66

⁸¹ “Central targets cut with new focus on health and well-being”. Department of Health press release, 2004/0269, 21 July 2004

Conclusions and recommendations

1. We recommend that Trusts be encouraged to identify 'clinical champions' to promote the benefits of telemedicine within the Trust and to ensure that the organisational and staff development requirements to make the system workable are in place. It is crucial to establish policies that enable the lessons of pilot programmes to be used in clinical delivery: at present it is often the case that the organisational requirements of integrating telehealthcare systems into hospital and primary care settings are rarely considered in R&D pilots. (Paragraph 17)
2. We recommend that when telecare systems are installed in the domiciliary environment, clinicians, technicians, health and social care workers, formal and informal carers and, most importantly, the patient are involved in determining the level of telecare that is suitable and acceptable to each individual recipient. It is essential that a balance between the use of technology and the continuation of human contact is an important element in any such judgement. (Paragraph 21)
3. Furthermore, evaluation needs to take account of the qualitative benefits for users and carers over time. There is a need to develop new ways of evaluating the qualitative benefits of new medical technologies in the long-term budgetary cycles. Methodologies are needed that can determine the social and economic benefits of new medical devices that fall outside the direct costs to the NHS. (Paragraph 22)
4. We recommend that the Department should seek to introduce a national system for reviewing and tracking the implementation of new devices over a number of years to ensure patient safety and efficacy issues are closely monitored. Currently there is no clear system for determining safety and efficacy beyond the clinical trials and evidence-based model of the Health Technology Assessment (HTA) programme while, there is also a need for developing more sophisticated measures of the utility of systems for patients that reflect more relevant criteria. Much greater patient participation in assessing the utility of telehealthcare is required. (Paragraph 23)
5. The Department should ensure that Primary Care Trusts (PCT) and hospital trusts (and if possible SHAs) should commission new technologies according to nationally approved standards (determined by the new Device Evaluation Service [DES] in conjunction with HTA/National Institute of Clinical Excellence [NICE]). Such standards should provide the basis for the selection of base-line devices and technologies. It is important that the tendency towards technology 'creep' and uneven mix of systems that lack interoperability or require different competences to be used should be avoided. Standardisation on clinical based systems should be undertaken in light of discussion with Social Services, who have a greater responsibility for telecare. (Paragraph 25)
6. We recommend that, when new medical technologies are introduced, protection of confidentiality and the privacy of the individual are key factors in the decision-making process. Privacy and confidentiality policies and protocols should be developed, implemented and audited when new technologies are introduced. (Paragraph 27)

7. There is also a need for a system of reporting with regard to the utility and limitations of telehealthcare systems or other devices that are 'near to patient'. It is clear that this will not be the responsibility of the reshaped DES, and there is currently no national 'clearing house, where this information might be lodged. This may well be a function for the Healthcare Commission. (Paragraph 51)
8. The Government has proposed some improvements to training, but these will not be sufficient. The Department should ensure that adequate training is in place to enable greater benefits to be derived from new technologies. To encourage greater familiarity with the possibilities and opportunities as well as limitations and risks of telemedicine, training should be modified in those specialist areas that are most likely to be primary users of telehealthcare such as pathology and radiology. Medical schools as well as the professional bodies should develop programmes to ensure effective training is put in place. Training in telecare for health care assistants working for social services and in the community also requires improvement to gain full benefits of new technologies. (Paragraph 54)
9. The Payment by Results scheme has been said to provide an incentive for new technologies, given its tie-in with the 18 week treatment target for patients (thereby encouraging Trusts to select those technologies and devices that can speed up care to meet the 18 week target). Devices that enable this to happen should be a key priority for the new DES. Given that in some cases the Trust that purchases and invests in new technologies may not necessarily be the beneficiary (or sole beneficiary), we recommend that the Department should build into the PbR tariff an incentive payment to offset these development and on-going costs. (Paragraph 58)
10. There is a need to differentiate tariffs for specialised devices/technologies and those that relate to basic care provision to ensure that the reimbursement structure properly reflects the level of complexity and pattern of use of new medical technologies. (Paragraph 59)
11. We welcome the initiatives already undertaken by the Department in this area. Now it must ensure that it devotes adequate attention and resources to rectifying the currently unstructured adoption of new medical technologies. (Paragraph 60)
12. We recommend that the Government in addition to its current proposals should address the following issues of concern to the Committee: problems relating to the inability to transfer budgets between holders; lack of clinical engagement and clinical champions; the impact of practice based commissioning on procurement; and an NHS preference for short-term savings to be made as opposed to long-term advantages for patients. (Paragraph 61)

List of abbreviations used in the report

ABHI	Association of British Healthcare Industries
DES	Device Evaluation Service
HITF	Healthcare Industries Task Force
HRG	Healthcare Resource Group
HTA	Health Technology Assessment
ICT	Information and Communications Technology
MHRA	Medicines and Healthcare products Regulatory Agency
MTG	The Medical Technology Group
NICE	National Institute of Clinical Excellence
NILSI	NHS Institute for Learning, Skills and Innovation
NPfIT	National Programme for Information Technology
PASA	NHS Purchasing and Supply Agency
PbR	Payment by Results
PCT	Primary Care Trust
QVH	Queen Victoria Hospital NHS Trust, East Grinstead

Formal minutes

Tuesday 5 April 2005

Members present:

Mr David Hinchliffe, in the Chair

Mr Keith Bradley

Dr Richard Taylor

Dr Doug Naysmith

The Committee deliberated.

Draft Report (The Use of New Medical Technologies within the NHS), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 61 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chairman do make the report to the House.

Ordered, That the Provisions of Standing Order No. 134 (Select Committee (Reports)) be applied to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

Witnesses

Thursday 3 March 2005

Professor Carl May, University of Newcastle upon Tyne; **Mr Baljit Dheansa**, Queen Victoria Hospital NHS Foundation Trust, East Grinstead; **Mr John Wilkinson**, Association of British Healthcare Industries; **Professor Sir James Underwood**, Royal College of Pathologists; **Mr Tony Rice**, Tunstall Group Ltd

Ev 1

Dr Felicity Harvey, Head of Medicines, Pharmacy and Industry Group, Department of Health; **Professor Tom Walley**, representing the Department of Health; **Professor Ian Philp**, National Director for Older People's Services, Department of Health; **Sir Christopher O'Donnell**, Co-chairman, Healthcare Industries Task Force.

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List of written evidence

1	Professor Carl May, Professor Frances Mair, Dr Maggie Mort, Dr Tracy Finch (MT 3)	Ev 1
2	Queen Victoria Hospital NHS Foundation Trust (MT 10)	Ev 3
3	Association of British Healthcare Industries (MT 24)	Ev 5
4	Royal College Of Pathologists (MT 12)	Ev 11
5	Tunstall Group Ltd (MT 32)	Ev 16
6	The Medical Technology Group (MT 44, 44A)	Ev 61, 72
7	Department of Health (MT 1)	Ev 29
8	Royal College of Radiologists (MT 6)	Ev 76
9	BUPA (MT 8)	Ev 86
10	Michael Tremblay (MT 15)	Ev 88
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12	British Geriatrics Society (MT 20)	Ev 96
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18	KCI Medical Ltd (MT 43)	Ev 124
19	QinetiQ Group plc (MT 52)	Ev 126
20	National Institute of Clinical Excellence (MT 55)	Ev 128

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Broomwell Healthwatch (MT 2)
 Saysell & Hargreaves (MT 4)
 British Society of Echocardiography (MT 5)
 BHTA (MT 7)
 Mr Eddie Chaloner (MT 9)
 Professor Sam H Ahmedzai (MT 11)
 The British Pain Society (MT 13)
 InfoMed (MT 14)
 SmartSensor telemed Ltd (MT 16)
 Maquet Ltd (MT 17)
 Royal College of Physicians (MT 19)
 Institute of Physics and Engineering in Medicine (MT 22)
 The British Pain Society - Intrathecal Drug Delivery Working Group (MT 23)
 Dr A Thanga Prabhu (MT 25)
 Medica Group (MT 27)
 Deltex Medical (MT 28)
 SADS UK (MT 29)
 The British Cardiac Patients Association (MT 31)
 RNID (MT 33)
 Bard Limited (MT 34)
 British Nuclear Medicine Society (MT 35)
 e.centre (MT 36)
 Boston Scientific (MT 37)
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 Parkinson's Disease Society (MT 42)
 Dr Daphne Austin (MT 45)
 Design Council (MT 46)
 Dr Jonathan Howell (MT 47)
 Royal College of Physicians of Edinburgh (MT 48)
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 Sirtex Medical Europe GmbH (MT 50)
 British Medical Association (MT 51)
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 Claud Regnard (MT 54)
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Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2004-05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99
Third Report	HIV/AIDS and Sexual Health	HC 252
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42

Session 2003-04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002-03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001-02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)

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